Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE ENROLLMENT/CHANGE 2007-2008

□ NEW EMPLOYEE □ QUALIFIED LIFE EVENT □ ADDRESS CHANGE □ TERMINATION

AGENCY CODE	AGENCY	DATE REC'D	EFFECTIVE DATE

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

A. EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE ID # or SSN	□ MALE □ FEMALE	□ MARRIED □ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	DATE OF EMPLOYMENT
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
SPOUSE'S LAST NAME, FIRST NAME	SPOUSE'S EMPLOYER	EMPLOYEE CURRENT SALARY	

B. MEDICAL PLAN (Employee Monthly Costs Listed)

□ I DECLINE MEDICAL COVERAGE

	CODE	SINGLE	CODE	EMP + 1	CODE	FAMILY
CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
United Healthcare (UHC) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Arizona Foundation (AZF) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
United Healthcare (UHC) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
SOUTHERN REGION: PIMA AND SANTA CRUZ COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
United Healthcare (UHC) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Arizona Foundation (AZF) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
United Healthcare (UHC) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
NORTHERN REGION: YAVAPAI, COCONINO, NAVAJO, AND APACHE COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Arizona Foundation (AZF) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
SOUTHEASTERN REGION: GRAHAM, GREENLEE, AND COCHISE COUNTIES						
RAN/AMN (HMA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Arizona Foundation (AZF) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
WESTERN REGION: MOHAVE, LA PAZ, AND YUMA COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00
Arizona Foundation (AZF) PPO	01	☐ $140.00	02	☐ $280.00	03	☐ $390.00
OUT-OF-STATE						
Beech Street PPO	01	☐ $25.00	02	☐ $50.00	03	☐ $125.00

Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE ENROLLMENT/CHANGE 2007-2008 CONTINUED

C. DENTAL PLAN (Monthly Costs Listed)	SINGLE COVERAGE		FAMILY COVERAGE	
☐ I DECLINE DENTAL COVERAGE	PLAN CODE		PLAN CODE	
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	03	☐ $14.56	04	☐ $54.14
METLIFE DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	07	☐ $12.90	08	☐ $45.00
EMPLOYERS DENTAL SERVICES (EDS) PRE-PAID IN-STATE ONLY	09	☐ $4.02	10	☐ $18.16
ASSURANT BENEFITS PRE-PAID IN-STATE ONLY	01	☐ $4.68	02	☐ $18.02

D. VISION PLAN (Monthly Cost Listed)

	Plan Code 05	Plan Code 06
☐ I DECLINE VISION COVERAGE	☐ AVESIS SINGLE COVERAGE $6.34	☐ AVESIS FAMILY COVERAGE $17.18

E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER). USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS	DATE OF BIRTH (MM/DD/YY) **REQUIRED**	MEDICARE	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N	ADD OR DELETE A OR D
Employee		**A=Medicare A B=Medicare B C=Medicare A & B D=Medicare unknown E=No Medicare**	**S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild**				
Spouse		☐ A ☐ B ☐ C ☐ D ☐ E	☐ S	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			

F. STANDARD SHORT-TERM DISABILITY

☐ **I DECLINE STANDARD SHORT-TERM DISABILITY** ☐ **I ELECT STANDARD SHORT-TERM DISABILITY**

G. STANDARD SUPPLEMENTAL LIFE INSURANCE AND DEPENDENT LIFE INSURANCE

Employee coverage maximum $300,000 in multiples of $5,000 not to exceed 3 times annual salary. Increases may not exceed $20,000 per plan year.

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE**

☐ Total amount of employee coverage $_____

☐ Non-Smoker (I have not smoked in 6 months, additional $1,000 benefit if Supplemental Life Insurance is elected).

Dependent Life Insurance

- ☐ **I DECLINE DEPENDENT LIFE INSURANCE**
- ☐ $2,000 $0.94/MTH Plan Code 02
- ☐ $4,000 $1.88/MTH Plan Code 04
- ☐ $6,000 $2.82/MTH Plan Code 06
- ☐ $12,000 $5.64/MTH Plan Code 12
- ☐ $15,000 $7.05/MTH Plan Code 15

H. PRIMARY BENEFICIARY (List additional or Trust information on a separate form which you may obtain from your benefit liaison)

Beneficiary Last Name, First Name	Date of Birth

Beneficiary Street, City, State, Zip Code	Phone No.

I. EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is correct and true. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In additon, I have read and understand the declarations.

SIGNATURE:_____ DATE:_____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 **Revised 08/01/07**